DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: Rev Buxite 96-24 11/6/97

2. STATE: Missouri

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
10-01-96

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR

7. FEDERAL BUDGET IMPACT:
a. FFY 97 $ 301,558
b. FFY 98 $ 301,558

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
4.19A- 1,2,3,4,5,6,17,18,19, & 20

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
4.19A - 1,2,3,3a,3b,3c,4,4a,5,5a,6,17,19,20, 20a,21,22,23,24,25,26,27,28,29,30

10. SUBJECT OF AMENDMENT: This amendment establishes and provides additional definitions used in t payment methodology for State Fiscal Year 1997 to pay hospitals for their unreimbursed Medicaid cost and their cost of the uninsured. This amendment also removes obsolete provisions that are no longer applicable to the Missouri State Plan for Hospitals.

11. GOVERNOR'S REVIEW *(Check One)*:

☒ GOVERNOR'S OFFICE REPORTED NO COMMENT JP
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
Gary J. Stangler

14. TITLE:
Director, Department of Social Services

15. DATE SUBMITTED:
12/30/96

16. RETURN TO:
Division of Medical Services
615 Howerton Court
Jefferson City, MO 65109

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
12/31/96

18. DATE APPROVED:

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
10-1-96

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:
Nanette Foster Reilly

22. TITLE: Acting
ARA for Medicaid & State Operations

23. REMARKS:
SPA CONTROL
Date Submitted 12/30/96
Date Received 12/31/96

FORM HCFA-179 (07-92)

Instructions on Back

STATE: Missouri

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

Inpatient Hospital Services Reimbursement Plan

13 CSR 70-15.010 Inpatient Hospital Services Reimbursement Plan

I. GENERAL REIMBURSEMENT PRINCIPLES

A. For inpatient hospital services provided for an individual entitled to Medicare Part A inpatient hospital benefits and eligible for Medicaid, reimbursement from the Missouri Medicaid program will be available only when Medicaid's applicable payment schedule amount exceeds the amount paid by Medicare. Medicaid's payment will be limited to the lower of the deductible and coinsurance amounts or the amount the Medicaid applicable payment schedule amount exceeds the Medicare payments. For all other Medicaid recipients, unless otherwise limited by rule, reimbursement will be based solely on the individual recipient's days of care (within benefit limitations) multiplied by the individual hospital's Title XIX per-diem rate. As described in paragraph V.D.2. of this rule, as part of each hospital's fiscal year-end cost settlement determination, a comparison of total Medicaid-covered aggregate charges and total Medicaid payments will be made and any hospital whose aggregate Medicaid per-diem payments exceed aggregate Medicaid charges will be subject to a retroactive adjustment.

B. The Title XIX reimbursement for hospitals located outside Missouri and for federally-operated hospitals in Missouri will be determined as stated in section (XIII) of this plan.

C. The Title XIX reimbursement for hospitals, excluding those located outside Missouri and in-state federal hospitals, shall include per-diem, outpatient, and disproportionate share payments. Reimbursement shall be subject to availability of federal financial participation (FFP).

1. Per-diem reimbursement - The per diem rate is established in accordance with section III. Hospitals and their per diem rates are described as either a general plan (GP) or disproportionate share (DS or DSH). The DS hospitals are described in section VI. and generally meet the mandated federal qualification and reimbursement criteria. Special state-defined DS hospitals are also described.

2. Oupatient reimbursement is described in Attachment 4.19B.

State Plan TN# 96-~~26~~ Effective Date 10/01/96
Supersedes TN# 87-12 Approval Date

3. Disproportionate share reimbursement - The discretionary disproportionate share payments which are allowable but not mandated under federal regulation are described in sections XV, XVI, and XVII. These UCACI, Safety Net, and Medicaid Add-Ons are subject to federal limitation described in OBRA 93 and section VI.D.

II Definitions.

A. Allowable costs. Allowable costs are those related to covered Medicaid services defined as allowable in 42 CFR chapter IV, part 413, except as specifically excluded or restricted in 13 CSR 70-15.010 or the Missouri Medicaid hospital provider manual and detailed on the desk reviewed Medicaid cost report. Penalties or incentive payments as a result of Medicare target rate calculations shall not be considered allowable costs. Implicit in any definition of allowable cost is that this cost is allowable only to the extent that it relates to patient care; is reasonable, ordinary and necessary; and is not in excess of what a prudent and cost-conscious buyer pays for the given service or item.

B. Bad debt - Bad debts should include the costs of caring for patients who have insurance but are not cover the particular services, procedures or treatment rendered. Bad debts should not include the cost of caring for patients whose insurance covers the given procedures buts limits coverage. In addition, bad debts should not include the cost of caring for patients whose insurance covers the procedure although the total payments to the hospital are less than the actual cost of providing care.

C. Base cost report--Desk-reviewed Medicare/Medicaid cost report for the latest hospital fiscal year ending during the calendar year. (For example, a provider has a cost report for the nine (9) months ending 9/30/94 and a cost report for the three (3) months ending 12/31/94.) If a hospital's base cost report is less than or greater than a twelve (12)-month period, the data shall be adjusted, based on the number of months reflected in the base cost report to a twelve (12)-month period.

D. Charity Care - results from a providers policy to provide health care services free of charge or a reduction in charges because of the indigence or medical indigence of the patient.

E. Contractual allowances--Difference between established rates for covered services and the amount paid by third-party payers under contractual agreements.

F. Cost report. A cost report details, for purposes of both Medicare and Medicaid reimbursement, the cost of rendering covered services for the fiscal reporting period. The Medicare/Medicaid Uniform Cost Report contains the forms utilized in filing the cost report.

G. Disproportionate Share Reimbursement. The discretionary disproportionate share payments which are allowed but not mandated under federal regulation are described in sections XV, XVI, and XVII of this regulation. These UCACI, Safety Net, Medicaid Add-Ons are subject to federal limitation as described in the Omnibus Reconciliation Act of 1993 (OBRA 93) and section VI.D., of this regulation.

H. Effective date.

1. The plan effective date shall be October 1, 1981.

2. The adjustment effective date shall be thirty (30) days after notification the hospital that its reimbursement rate has been changed unless modified by other sections of the plan.

I. Medicare rate. The Medicare rate is the rate established on the basis of allowable cost as defined by applicable Medicare standards and principles of reimbursement (42 CFR part 405) as determined by the servicing fiscal intermediary based on yearly Hospital Cost Reports.

J. Nonreimbursable items. For purposes of reimbursement of reasonable cost, the following are not subject to reimbursement:

1. Allowances for return on equity capital;

2. Amounts representing growth allowances in excess of the intensity allowance, profits, efficiency bonuses, or a combination of these;

3. Cost in excess of the principal of reimbursement specified in 42 CFR chapter IV, part 413; and

4. Costs or services or costs and services specifically excluded or restricted in this plan or the Medicaid hospital provider manual.

K. Per Diem rates. The per diem rates shall be determined from the individual hospital cost report:

1. General Plan Per diem rate is calculated in accordance with section III. of the regulation. This rate is paid to hospitals not meeting the disproportionate criteria in section 6 of this regulation;

2. Disproportionate share per diem rate is calculated in accordance with section VI. of this regulation for hospitals that met the Federally mandated disproportionate share criteria or the state specific criteria established in section VI. of this regulation.

L. Reasonable cost. The reasonable cost of inpatient hospital services is an individual hospital's Medicaid per-diem cost per day as determined in accordance with the general plan rate calculation from section III of this regulation using the base year cost report {by dividing allowable Medicaid inpatient costs by total Medicaid inpatient days, including nursery days}.

M. Trend factor. The trend factor is a measure of the change in costs of goods and services purchased by a hospital during the course of one (1) year.

N. Children's hospital. An acute care hospital operated primarily for the care and treatment of children under the age of eighteen (18) and which has designed in its licensure application at least sixty-five percent (65%) of its total licensed beds as a pediatric unit as defined in 19 CSR 30-20.021(4)(F).

O. Hospital-sponsored primary care clinic--A clinic location which has met all of the following criteria:

1. The clinic shall not be physically located within a licensed hospital;

2. The clinic must be enrolled as a Medicaid provider;

3. The clinic is not certified by the Division of Health Standards and Quality, Health Care Financing Administration (HSQ/HCF) as being part of any hospital; and

4. The sponsoring hospital has completed and returned the Hospital-Sponsored Primary Care Clinic Application to the Missouri Division of Medical Services by May 1, 1994, providing verification of the following:

A. The sponsoring hospital and the clinic are subject to the bylaws and operating decisions of the same governing body; or

B. The sponsoring hospital contributes at least five hundred thousand dollars ($500,000) annually towards the operation of the clinic.

III. Per-Diem Reimbursement Rate Computation.
Each general plan (GP) hospital shall receive a Medicaid per-diem rate based on its GP rate compiled in accordance with subsection III.A. Each disproportionate share hospital shall receive a rate compiled in accordance with subsection III.B.

A. The GP rate shall be the lower of the most current Title XVIII Medicare rate or the GP per diem determined from the 1990 base year cost report in accordance with the following formula:

Substitute per letter dated 2/19/97 *

$$\text{GP PER DIEM} = \frac{(OC * TI)}{MPD} + \frac{CMC}{MPDC}$$

1. OC-The operating component is the hospital's TAC less CMC;

2. CMC-The capital and medical education component of the hospital's TAC;

3. MPD-Medicaid inpatient days;

4. MPDC-MPD as defined in III.A.3. with a minimum utilization of sixty percent (60%) as described in paragraph V.C.4.;

5. TI-Trend Indices. The trend indices are applied to the OC of the per-diem rate. The trend indices for SFY 90 is used to adjust the OC to a common fiscal year end of June 30;

6. TAC-Allowable inpatient routine and special care unit expenses, ancillary expenses and graduate medical education costs will be added to determine the hospital's total allowable cost (TAC);

7. The GP per diem shall not exceed the average Medicaid inpatient charge per diem as determined from the base year cost report and adjusted by the TI.

8. The general plan per diem shall be adjusted for rate increases granted in accordance with subsection V.F., for allowable costs not included in the base year cost report.

B. Disproportionate Share (DS) Rate. The DS rate determined in accordance with section 6 using the 1993 base year cost report shall be adjusted by the trend indices (TI) for subsequent state fiscal years.

C. Trend Indices (TI). Trend indices are determined based on the four (4) quarter average DRI Index for PPS-Type Hospital Market Basket as published in Health Care Costs by DRI/McGraw-Hill.

1. The TI are-

A. State Fiscal Year 1990-5.30%;
B. State Fiscal Year 1991-5.825%;
C. State Fiscal Year 1992-5.33%;
D. State Fiscal Year 1993-4.68%;
E. State Fiscal Year 1994-4.6%;
F. State Fiscal Year 1995-4.45%;
G. State Fiscal Year 1996-4.575%.
H. State Fiscal Year 1997-4.05%.

2. The TI for SFY 90 through SFY 92 are applied as a full percentage to the OC of the per-diem rate. The TI for SFY 93 through SFY 94 are applied one-half (1/2) to the individual hospital OC and one-half (1/2) times the statewide average weighted per-diem rate as of June 30. Only one-half (1/2) of the TI for SFY 95 through SFY 97 are applied to the individual hospital per diem rate. The remaining TI is considered in the Medicaid Add-On payment.

IV. Per-diem Rate -New Hospitals.

A. Facilities Reimbursed by Medicare on a Per-Diem Basis. In the absence of adequate cost data, a new facility's Medicaid rate may be its most current Medicare rate on file for two (2) fiscal years following the facility's initial fiscal year as a new facility. The Medicaid rate for this third fiscal year will be the lower of the most current Medicare rate on file by review date or the facility's Medicaid rate for its second fiscal year indexed forward by the inflation index for the current fiscal year. The Medicaid rate for the facility's fourth fiscal year will be determined in accordance with sections I.,-III., of this plan.

B. Facilities Reimbursed by Medicare on a DRG Basis. In the absence of adequate cost data, a new facility's Medicaid rate may be one hundred twenty percent (120%) of the average-weighted, statewide per-diem rate for two (2) fiscal years following the facility's initial fiscal year as a new facility. The Medicaid rate for the third fiscal year will be the facility's Medicaid rate for its second fiscal year indexed forward by the inflation index for the current fiscal year. The Medicaid rate for the facility's fourth fiscal year will be determined in accordance with sections I.,-III., of this plan.

V. Administrative Actions

A. Cost Reports

1. Each hospital participating in the Missouri Medical Assistance Program shall submit a cost report in the manner prescribed by the state Medicaid agency. The cost report shall be submitted within five (5) calendar months after the close of the reporting period. The period of a cost report is defined in 42 CFR 413.24(f). A single extension, not to exceed thirty (30) days, may be granted upon request of the hospital and the approval of the Missouri Divison of Medical Services when the provider's operation is significantly affected due to extraordinary circumstances over which the provider had no control such as fire or flood. The request must be in writing and post marked prior to the first day of the sixth (6th) month following the hospital's fiscal year end.

Substitute per letter dated 2/19/97

XV. UCACI Adjustments-Disproportionate Share. A UCACI adjustment shall be provided for disproportionate share hospitals prior to the end of each federal fiscal year, as described in this section.

A. Subject to paragraph XV.A.2., hospitals which qualified as disproportionate share hospitals in the payment year under the provisions of part VI.A.4., and were granted disproportionate share rates available to those hospitals in the payment year, the UCACI adjustment shall be-

1. The hospitals' THC times the hospitals' MIUR times incentive/access/ adjustment factor of one hundred twenty-five percent (125%), less TMMPR. A hospital with a cost-to-charge ratio of less than fifty percent (50%) will have its THC amount adjusted downward to the fifty percent (50%) limit. For example:

UCACI=((THC (Adjusted)) x MIUR x 125%) -TMMPR

and

2. The hospitals qualifying in section XV.A., in the aggregate, must have Cash Subsidies (CS) sufficient to support the matching requirement of the aggregate adjustment amount. If the aggregate CS are less than the matching amount required, the total aggregate adjustment will be adjusted downward accordingly, and distributed to the hospitals in the same proportions as the original adjustment amounts.

B. The data sources, reports and data definitions for determining the UCACI shall be the same as described in paragraph VI.A.2., and adjusted as may be described in paragraphs XV.A.1. Hospitals which do not have a third prior fiscal year cost report described in paragraph VI.A.2., shall not be eligible for a UCACI adjustment. No amended cost reports shall be accepted after the division's annual determination of the adjustment amount. For state FY 91, the determination date shall be March 12, 1991. For state FY 92 and after, the determination date shall be no later than thirty (30) days following the beginning of the fiscal year. For example, for state FY 92, the determination date will be no later than August 1, 1991.

C. Adjustments provided under this section shall be considered reasonable costs for purposes of the determinations described in paragraph V.D.2.

XVI. Safety Net Adjustment. A safety net adjustment shall be provided for each hospital which qualified as disproportionate share under the provision of part VI.A.4., prior to the end of each federal fiscal year.

A. The safety net adjustment shall be computed as follows:

1. The safety net adjustment shall be equal to the lesser of CC charges or total unreimbursed hospital charges. Unreimbursed hospital charges are computed as THC less patient revenues and UCACI adjustments computed in accordance with subsection XV.A. In the case of nominal charge providers whose total charges are less than cost, total hospital costs shall be substituted for THC;

2. If the aggregate CS are less than the matching amount required, the total aggregate safety net adjustment will be adjusted downward accordingly, and distributed to the hospitals in the same proportions as the original safety net adjustments;

3. The data sources, reports and data definitions for determining the safety net adjustment shall be the same as described in paragraph VI.A.2., and adjusted as may be described in this rule. Hospitals which do not have a third prior fiscal year cost report described in paragraph VI.A.2., shall not be eligible for a safety net adjustment. No amended cost reports shall be accepted after the division's annual determination of the adjustment amount; and

4. Adjustments provided under this section shall be considered reasonable costs for purpose of the determinations described in paragraph V.D.2.

XVII. In accordance with state and federal laws regarding reimbursement of inpatient and outpatient hospital services and the implementation of a Medicaid managed care system, reimbursement for state fiscal year 1997 (July 1, 1996 - June 30, 1997) shall be determined as follows.

A. State Fiscal Year 1997 Reimbursement for Inpatient and Outpatient Hospital Services

1. Claims for inpatient and outpatient hospital services for Missouri Medicaid eligible recipients, not enrolled in a Medicaid managed care plan such as MC+, shall continue to be reimbursed in accordance with current regulations and claims processing procedures.

2. Inpatient per diem rates in effect as of June 30, 1996, shall be adjusted by one-half of the trend indices applicable for state fiscal year 1995, 1996, and 1997. Per diem rates for hospitals which initially qualify July 1, 1996, as first or second tier Disproportionate Share or hospitals which previously qualified as first or second tier and failed to requalify July 1, 1996 shall be adjusted to a disproportionate share or general plan level as appropriate.

3. Medicaid Add-on payments based on one hundred percent (100%) of the allocated Medicaid shortfall and ninety-nine percent (99%) of the cost of the uninsured shall be prorated over SFY 97. Hospitals which contribute through a plan approved by the director of health to support the state's poison control center and the Primary Care Resource Initiative for Missouri (PRIMO) shall receive a Medicaid Add-on payment based on one hundred percent (100%) of the allocated Medicaid shortfall and one hundred percent (100%) of the cost of the uninsured.

B. Medicaid Add-Ons

1. Medicaid Add-Ons for Shortfall and Uninsured are based on the estimated inpatient and outpatient cost attributable to Medicaid and the cost of the Uninsured for SFY 97 less the estimated per diem and outpatient reimbursement for SFY 97. The Add-on payments for cost of the Uninsured are not considered in the determination of inpatient recoupments described in section V.D.2.

2. The estimated inpatient cost for SFY 97 is based on the desk reviewed base year cost per day, trended thru SFY 97, and multiplied by the estimated inpatient days for SFY 97. The estimated outpatient cost is based on the base year outpatient cost trended thru SFY 97. The base year is the third prior fiscal year (i.e., The base year for SFY 97 is the FY 94 cost report.)

3. The estimated per diem reimbursement for SFY 97 is based on the current per diem rate multiplied by the inpatient days, within benefit limitations, estimated to be paid for SFY 97. The estimated outpatient reimbursement is based on payment at ninety percent (90%) of base year cost trended thru SFY 97.

4. An adjustment to recognize the FRA assessment not included in the desk reviewed cost per day is also included. The FRA assessment attributable to Medicaid and Uninsured is determined by multiplying the ratio of base year Medicaid and Uninsured days to total inpatient days by the SFY 97 FRA assessment .

5. An adjustment shall also be determined for hospitals which operated a poison control center during the base year and which continues to operate a poison control center in a Medicaid managed care region. The Add-On adjustment shall reimburse the hospital for the prorated Medicaid managed care cost in accordance with the allocation formula described in the Allocation of Medicaid Add-Ons section; and

6. The Add-On payment for the cost of the uninsured is determined by multiplying the charges for charity care and allowable bad debts by the hospital's total cost-to-charge ratio from the base year cost report's desk review. The cost of the uninsured is then trended to the current year. Allowable bad debts do not include the costs of caring for patients whose insurance covers the particular service, procedure or treatment; and

C. Allocation of Medicaid Add-Ons.

1. Medicaid Add-Ons determined for Medicaid shortfall and cost of the Uninsured shall be allocated based on the estimated effect of implementation of an MC+ in accordance with this section. Medicaid per-diem and outpatient payments, which are paid on a claim-specific basis do not require an allocation.

2. Medicaid Add-Ons shall be multiplied by a managed care allocation factor which incorporates, the estimated percentage of the hospitals Medicaid population which will remain outside a managed care system and the estimated implementation date for a managed care system. For example: If a hospital has 1) an annual Add-On payment of $100,000, 2) 40% of their Medicaid days are related to Medicaid recipients not eligible for Medicaid managed care, and 3) the projected implementation date for managed care is October 1, 1995; the prorated Medicaid Add-On is $55,000 [($100,000 25%)+ ($100,000 75% 40%)].

3. The Medicaid Add-On shall include an adjustment to recognize the FRA assessment for the estimated SFY 97 Medicaid inpatient days allocated due to the implementation of MC+.

XIX Medicaid GME Add-On--A Medicaid Add-On determined for Graduate Medical Education (GME) costs shall be allocated based on the estimated effect of implementation of a Medicaid managed care system such as MC+ in accordance with this section.

A. The Medicaid GME Add-On for Medicaid clients covered under a Managed Care Plan shall be determined using the base year cost report and paid in quarterly installments. The base year cost report shall be the third prior fiscal year (i.e., The base year for SFY 1997 is the FY 1994 cost report). The hospital per diem shall continue to include a component for GME related to Medicaid clients not included in a managed care system.

1. Total GME cost shall be multiplied by a managed care allocation factor which incorporates the estimated percentage of the hospital's Medicaid population included in a managed care system and the estimated implementation date for a managed care system. For example: If a hospital has 1) an annual GME cost of one hundred thousand dollars ($100,000), 2) forty percent (40%) of their Medicaid days are related to Medicaid recipients eligible for Medicaid managed care, and 3) the projected implementation date for managed care is October 1, 1995; the prorated GME Add-On is thirty thousand dollars ($30,000).

2. The annual GME Add-On shall be paid in quarterly installments.

INSTITUTIONAL STATE PLAN AMENDMENT
ASSURANCE AND FINDING CERTIFICATION STATEMENT

STATE: Missouri TN - 96-~~26~~ 41

REIMBURSEMENT TYPE: Inpatient hospital X

PROPOSED EFFECTIVE DATE: October 1, 1996

A. State Assurances and Findings. The State assures that is has made the following findings:

1. 447.253 (b) (1) (i) - The State pays for inpatient hospital services through the use of rates that are reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated providers to provide services in conformity with applicable State and Federal laws, regulations, and quality and safety standards. _____

2. With respect to inpatient hospital services - -

   a. 447.253 (b) (1) (ii) (A) - The methods and standards used to determine payment rates take into account the situation of hospitals which serve a disproportionate number of low income patients with special needs. _____

   b. 447.253 (b) (1) (ii) (B) - If a state elects in its State plan to cover inappropriate level of care services (that is, services furnished to hospital inpatients who require a lower covered level of care such as skilled nursing services or intermediate care services) under conditions similar to those described in section 1861 (v) (1) (G) of the Act, the methods and standards used to determine payment rates must specify that the payments for this type of care must be made at rates lower than those for inpatient hospital level of care services, reflecting the level of care actually received, in a manner consistent with section 1861 (v) (1) (G) of the Act. _____

   If the answer is "not applicable," please indicate:

   _____

c. 447.253 (b) (1) (ii) (C) - The payment rates are adequate to assure that recipients have reasonable access, taking into account geographic location and reasonable travel time, to inpatient hospital services of adequate quality. _____

4. 447.253 (b) (2) - The proposed payment rate will not exceed the upper payment limits as specified in 42 CFR 447.272:

a. 447.272 (a) - Aggregate payments made to each group of health care facilities (hospitals, nursing facilities, and ICFs/MR) will not exceed the amount that can reasonably be estimated would have been paid for those services under Medicare payment principles. _____

b. 447.272 (b) - Aggregate payments to each group of State-operated facilities (that is, hospitals, nursing facilities, and ICFs/MR) - - when considered separately - - will not exceed the amount that can reasonably be estimated would have been paid for under Medicare payment principles. _____

If there are no State-operated facilities, please indicate "not applicable:"

_____

c. 447.272 (c) - Aggregate disproportionate share hospital (DSH) payments do not exceed the DSH payment limits at 42CFR 447.296 through 447.299.

d. Section 1923 (g) _ DSH payments to individual providers will not exceed the hospital-specific DSH limits in section 1923(g) of the Act. _____

B. State Assurances. The State makes the following additional assurances:

1. For hospitals - -

a. 447.253 (c) - In determining payment when there has been a sale or transfer of the assets of a hospital, the State's methods and standards provide that payment rates can reasonably be expected not to increase in the aggregate solely as a result of changes of ownership, more than payments would increase under Medicare under 42 CFR 413.130, 413.134, 413.153 and 413.157 insofar as these sections affect payment for depreciation, interest on capital -indebtedness, return on equity)if applicable), acquisition costs for which payments were previously made to prior owners, and the recapture of depreciation.

3. 447.253 (e) - The State provides for an appeals or exception procedure that allows individual providers an opportunity to submit additional evidence and receive prompt administrative review, with respect to such issues as the State determines appropriate, of payment rates.

4. 447.253 (f) - The State requires the filing of uniform cost reports by each participating provider.

5. 447.253 (g) - The State provides for periodic audits of the financial and statistical records of participating providers.

6. 447.253 (h) - The State has complied with the public notice requirements of 42 CFR 447.205.

Notice published on: Sept. 28, 1996
If no date is shown, please explain:

7. 447.253 (i) - The State pays for inpatient hospital services using rates determined in accordance with the methods and standards specified in the approved State plan.

C. Related Information

1. 447.255 (a) - NOTE: If this plan amendment affects more than one type of provider (e.g., hospital, NF, and ICF/MR; or DSH payments) provide the following rate information for each provider type, or the DSH payments. You may attach supplemental pages as necessary.

Provider Type: Hospital

For hospitals: The Missouri Hospital Plan includes DSH payments in the estimated average rates. However, the DSH payments included in the estimated average rates do not represent the total DSH payments made to hospitals under the Missouri Medicaid Plan.

Estimated average proposed payment rate as a result of this amendment:
$677.46

Average payment rate in effect for the immediately preceding rate period:
$640.36

Amount of change: $37.10 Percent of change: 5.79%

2. 447.255 (b) - Provide an estimate of the short-term and, to the extent feasible, long-term effect the change in the estimated average rate will have on:

(a) The availability of services on a statewide and geographic area basis:
This amendment will not effect the availability of short-term or long-term services.

(b) The type of care furnished: This amendment will not effect hospital services furnished to Medicaid eligibles.

(c) The extent of provider participation: This amendment will assure recipients have reasonable access taking into account geographic location and reasonable travel time to inpatient hospital services.

(d) For hospitals - - the degree to which costs are covered in hospitals that serve a disproportionate number of low income patients with special needs:
It is estimated that disproportionate share hospitals will receive 100% of their Medicaid costs for low income patients with special needs.